

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2009
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NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW WASHINGTON, DC 20012
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from May 18, 2009 through May 19, 2009. The survey was initiated using the full survey process. A random sample of two clients was selected from a resident population of one female and three males with various disabilities.</p> <p>The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident and investigation reports.</p>	W 000	<p><i>Received 6/10/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients' involved family members and/or legal guardians were notified of significant incidents, for two of the four clients residing in the facility. (Clients #1 and #4)</p> <p>The findings include:</p> <p>1. Interview with the Qualified Mental Retardation Professional (QMRP) on May 18, 2009, at approximately 10:30 AM revealed Client #1 had a legal guardian that was involved in his habilitation and care. The facility's incident reports and corresponding investigations were reviewed on</p>	W 148	<p>1. In the future, the QMRP will contact Client #1's legal guardian to report all incidents in a timely manner.</p> <p>2. The QMRP will contact Client #2's medical guardian of health-related discussions. The discussions will be reflected in the QMRP monthly notes.</p>	<p>6/8/09</p> <p>6/22/09</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Constance C. Reese* TITLE: *Program Director* (X6) DATE: *6/9/09*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 148	<p>Continued From page 1 the same day, beginning at 10:47 AM.</p> <p>a. According to an incident report, Client #1 incurred a head injury (cut to his forehead) on January 18, 2009, when he reportedly became frustrated from not being able to "bite" staff.</p> <p>b. Another incident report documented that on May 14, 2009, Client #1 incurred another head injury (cut to his forehead) during a similar behavioral episode.</p> <p>Neither incident report reflected notification of the client's guardian. On May 18, 2009, at approximately 11:15 AM, the QMRP acknowledged that Client #1's guardian was not made aware of the aforementioned incidents.</p> <p>2. Similarly, the facility failed to document having notified Client #4's guardian and involved family member of the following incidents:</p> <p>a. According to an incident report dated November 20, 2008, Client #4 was bitten on the upper left side of the back by Client #1, at 6:45 AM. Further review of the incident report revealed no evidence that the client's medical guardian or family member had been notified of the incident, in accordance with agency policies.</p> <p>b. Another incident report, dated October 16, 2009, documented that Client #1 had bitten Client #4 on his elbow that morning, at 8:00 AM. The facility had documented notification of the family member that same day, at 5:00 PM. There was no evidence, however, that the guardian had been notified.</p> <p>This is a repeat deficiency.</p>	W 148		

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W 148	Continued From page 2 ***** Previously, the September 5, 2008 deficiency report had cited the failure to notify Client #1's guardian after he sustained two injuries. On August 18, 2008, he sustained a 3-inch abrasion on his right shoulder, the cause of which was undetermined. on August 20, 2008, staff witnessed him injuring his forehead during a behavioral episode. Telephone interview with the guardian revealed that she had not been notified of either injury.	W 148			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP), for four of the four clients residing in the facility. (Clients #1, #2 and #4) The findings include: 1. Cross-refer to W148. The QMRP failed to ensure that the involved family members and/or legal guardians were notified of significant incidents involving Clients #1 and #4. 2. Cross-refer to W252. The QMRP failed to ensure staff documented behavior data in	W 159	1. Cross reference W148 2. Cross reference W252 3. Cross reference W227 4. Cross reference W148	6/8/09 6/8/09 6/22/09 6/8/09	

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W 159	<p>Continued From page 3 accordance with Client #1's behavior support plan.</p> <p>3. Cross-refer to W227. The QMRP failed to ensure Client #1 received training based on recommendations in his comprehensive functional assessment.</p> <p>4. The QMRP failed to maintain documentation of health-related discussions with Client #2's sister/ medical guardian, as follows:</p> <p>On May 19, 2009, at 9:00 AM, review of Client #2 urology documents revealed that on March 6, 2008, the urologist had indicated "recurrent urinary tract infections... recommend circumcision since he has phimosis... it is highly likely that it is contributing to recurrent UTI..." More recent urology reports, however, did not repeat the same recommendation. The urologist's recommendation of circumcision had not been reflected in QMRP or Social Work quarterly reviews following the March 2008 appointment (reviewed the previous day, at 3:10 PM and 3:15 PM, respectively). The recommendation also was not reflected in the client's quarterly nursing assessments from 2008 and 2009 (reviewed May 19, 2009 at 9:10 AM). At 9:50 AM, the current QMRP stated that she recalled Client #2's medical guardian (and sister) having told a former QMRP that she did not want her brother circumcised. The QMRP agreed to seek documentation of said conversation(s). No additional information, however, was provided before the end of the survey.</p> <p>5. Similarly, the QMRP failed to document in Client #2's record alleged attempts to address a recommendation for reading glasses, as follows:</p>	W 159	<p>5. The QMRP will ensure that Client #2 will receive reading glasses. The Residential Manager and staff will also encourage Client #2 to use his reading glasses whenever necessary.</p>	6/15/09	

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W 159	<p>Continued From page 4</p> <p>On May 18, 2009, beginning at 2:22 PM, review of Client #2's Individual Support Plan (ISP) dated July 31, 2008 revealed that he wore eye glasses. The client, however, had not been observed wearing glasses in the home that morning or at his day program later in the day.</p> <p>His ophthalmology records were reviewed on May 19, 2009, at 8:50 AM. On January 6, 2009, the ophthalmologist wrote: "Patient does not need eye glasses for distance vision. May use reading glasses at +2.00 bought over the counter at... pharmacy." At 9:10 AM, review of the client's quarterly nursing assessments failed to show evidence that the nurse had addressed the issue of reading glasses. At 9:30 AM, the House Manager (HM) and a direct support staff (S11) were asked about his eye glasses. The HM recalled there having been discussion at his recent (May 12, 2009) ISP meeting (draft report not yet available). Staff S11 said she had accompanied him to the ophthalmologist on January 6, 2009. The client reportedly had told her that he did not want reading glasses. Further review of the client's record, however, failed to show evidence of this or other discussions with the client about his recommended reading glasses.</p> <p>Later that day, Client #2 was interviewed after he returned home from day program. At approximately 3:50 PM, he stated that he had lost his glasses "in the van" approximately 1 year earlier. At first he denied having been back to an eye doctor, however, he did acknowledge the January 6, 2009 appointment once it was brought to his attention. He then asked how much new glasses would cost. A few minutes later, he</p>	W 159			

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W 159	<p>Continued From page 5</p> <p>examined a magazine on the dining room table, first without reading glasses, then with a pair of reading glasses afterwards. He said he could see without them but could see better with the glasses on. The QMRP was present at that time. She said he could use his personal funds to purchase reading glasses if he chose.</p> <p>During the exit conference a short while later, the QMRP indicated that there had been additional conversations with Client #2. She agreed, however, that information pertaining to the issue of reading glasses had not been documented in the client's record. There was no documented evidence that the facility had addressed the ophthalmologist's January 6, 2009 recommendation for reading glasses.</p>	W 159		
W 189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record verification, the facility failed to ensure MANDT (crisis intervention) training before staff were assigned to work with Client #1, in accordance with his behavior support plan, for one of the four staff providing one-on-one supports. (S12)</p> <p>The finding includes:</p> <p>On May 18, 2009, at 9:21 AM, an employee (S12) entered the facility. The Qualified Mental Retardation Professional (QMRP) and House Manager (HM) introduced him. The employee</p>	W 189		

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W 189	Continued From page 6 would provide Client #1 with one-on-one support for the remainder of the 8:00 AM - 4:00 PM shift. He indicated that he had been working as the client's one-on-one during the 4:00 PM - 12:00 AM shift for the past week and a half. The QMRP and HM confirmed this and listed the training that he had received. A short while later, at approximately 9:45 AM, the QMRP and HM indicated that Client #1 received one-on-one staff support 24 hours a day, 7 days a week. Further interview revealed that the client's behavior support plan (BSP) incorporated the use of physical restraint as a last resort; staff, therefore, had been trained on MANDT crisis intervention techniques. On May 18, 2009, beginning at approximately 11:30 AM, review of Client #1's BSP, dated April 30, 2009, confirmed that all staff working with him must be "trained and certified in nonviolent crisis intervention procedures... such as MANDT," to ensure the client's safety. On May 19, 2009, beginning at 10:37 AM, review of the facility's personnel files revealed no evidence that one of Client #1's one-on-one staff (S12) had received MANDT training. At the conclusion of the survey, at approximately 5:10 PM, the QMRP acknowledged that S12 had not yet received MANDT training.	W 189	The one to one staff will receive MANDT training. In the future, staff will receive adequate training prior to working with Client #1.	7/19/09	
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.	W 227			

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W 227	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop a training program to address an assessed need, for one of two clients in the sample. (Clients #1)</p> <p>The finding includes:</p> <p>During breakfast on May 18, 2009, at approximately 7:35 AM, Client #1 wore a bib. There was significant spillage of food during the meal. His 1:1 staff used a napkin to wipe the client's mouth throughout the meal. Similar observations were made at dinner that evening and the following next evening as well.</p> <p>On May 19, 2009, at 1:07 PM, review of the client's record revealed an Occupational Therapy (OT) assessment dated August 14, 2008 in which the OT proposed a training objective "to utilize napkins at all self/staff feeding times to wipe his mouth." The client would complete the task with verbal prompting and hand over hand physical assistance. The OT assessment, however, had been received after the interdisciplinary team (IDT) had met on July 31, 2008 to review his programs.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on same day, at approximately 1:10 PM, revealed that she was previously unaware of the proposed training program. The program had never been implemented. There was no evidence that the OT's original recommendation had been addressed by the IDT since the assessment was received by the facility in August of last year.</p> <p>The OT reportedly re-assessed Client #1 in</p>	W 227	The QMRP will request the occupational therapist to reassess Client #1's ability to complete proposed training objective. In the future, the QMRP will develop a training program to address an assessed need of Client #1.	6/22/09	

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W 227	Continued From page 8 preparation for his May 12, 2009 annual team meeting. The QMRP did not, however, have the OT's assessment report in the facility. When asked about the OT's recommendations, the QMRP stated that she was not sure whether he had repeated his recommendation for a napkin/ mouth wiping program. She further indicated that the report might be received "by the end of this week."	W 227		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on staff and client interview and record review, the facility failed to ensure that individual program plans reflected choice and self-management, for one of the two clients in the sample. (Client #2) The findings include: On May 18, 2009, at approximately 12:30 PM, interview with Client #2's day program activities coordinator revealed that the client routinely purchased diet cola and/or coffee at the cafeteria located in the same building. Those were known to be his two favorite beverages. The client confirmed this when interviewed the next day, at 4:30 PM. He said that residential staff had stopped purchasing coffee and told him it was because it contained caffeine. Further interview revealed that the client was previously unaware that there was caffeine in the diet cola he drank. In addition, the client stated that the person(s) who had told him that caffeine was bad for him	W 247		

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W 247	Continued From page 9 were neither his doctor or nurse. The House Manager (HM) and a staff person (S9) had been asked about Client #2's preference for coffee earlier that day. At 10:09 AM, the HM stated that coffee was not kept in the house. Staff person S9 stated that Client #2 should not have coffee because he was "on a diet." [Note: His diet plan was 1500 calorie, low fat, low cholesterol, high fiber.] Review of the client's May 2009 physician's orders did not reveal a caffeine restriction. S9 further indicated that she did the grocery shopping. She purchased what was listed on the facility's menus. She presented the menus, which consistently showed skim milk as the (only) beverage. Further discussion with the HM and S9 revealed that the issue of providing Client #2 (and his peers) a choice of beverage other than skim milk had not been discussed, to date. Later, at approximately 5:00 PM, when the topic was addressed during the exit conference, the RN suggested that caffeine might be contra-indicated due to Client #2's urinary incontinence. She acknowledged, however, that the client's physician had not ordered a caffeine restriction. There was no evidence that the facility had determined how Client #2's choice of beverages would be reflected in his program.	W 247	1. Client #2 will be given an opportunity to choose a beverage of his choice. Staff will receive additional training on how to encourage Client #2 to make choices. 2. The QMRP will request an updated nutritional assessment from the nutritionist to address if Client #2 has a caffeine restriction.	6/8/09	6/15/09
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252			

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W 252	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to document behavior data in accordance with the behavior support plan (BSP), for one of the two clients in the sample. (Client #1) The finding includes: During the afternoon on May 18, 2009, Client #1 was observed attempting to bite his 1:1 staff at approximately 2:40 PM and again at 3:53 PM. At approximately 5:53 PM, he observed attempting to bite his evening 1:1 staff, three times within a minute. Client #1 was escorted to his bedroom to protect staff and peers. Earlier interview with the 1:1 staff, at approximately 3:55 PM, revealed that biting/ attempting to bite was one of Client #1's maladaptive behaviors. On May 19, 2009, at 11:30 AM, review of Client #1's BSP dated April 9, 2009 confirmed that one of his targeted behaviors was biting/ attempting to bite. The BSP further revealed Client #1 should be monitored on an ongoing basis and "all" challenging behaviors should be recorded accurately and consistently on data collection sheets. Review of the ABC behavior data collection sheets, however, revealed that staff had not documented Client #1's biting attempts on the previous day. At approximately 3:20 PM, the Qualified Mental Retardation Professional acknowledged that staff had not documented the biting attempts as required.	W 252	The one to one staff will receive training on documenting ABC behavior data collection sheets. This collection of data will be monitored by QMRP and Residential Manager.	6/8/09	
W 338	483.460(c)(3)(v) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in	W 338			

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W 338	Continued From page 11 any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on interview and record review, facility nurses failed to refer clients for serum lab testing at the frequency specified on the physician's orders, for one of the two clients in the sample. (Client #2). The finding includes: On May 18, 2009, beginning at 3:33 PM, review of Client #2's medical records revealed that his diagnoses included depression, urinary incontinence and hypercholesterolemia, for which he was prescribed medications (Lexapro, Oxybutynin chloride and Simvastatin, respectively). In addition, he was prescribed a 1500 calorie low fat, low cholesterol, high fiber diet. Client #2's physician's orders (POs) for May 2009 included instructions to "monitor liver function tests and lipid panel every 3 months." Review of past POs revealed that previously, those labs had been ordered every 6 months. However, the lab orders had been changed to every 3 months, effective December 1, 2008. At 3:52 PM, review of his lab reports revealed that his LFT and lipid panel had been tested on December 18, 2008 and April 21, 2009 (4 months apart). When discussed at the exit conference the following day, the RN acknowledged that the orders read every 3 months.	W 338	The primary nurse will review the physician order sheet to make sure all ordered lab test are done on a timely manner.	6/8/09	
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions.	W 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/31/2009
FORM APPROVED
OMB NO. 0938-0391

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W 441	Continued From page 12 This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for four of four clients residing in the facility. (Clients #1, #2, #3 and #4) The finding includes: Review of the facility's fire drill records on May 18, 2009, at 10:00 AM, revealed staff documented having evacuated clients via the front, side, and basement door exits on all drills. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 10:20 AM, revealed that the facility's emergency fire evacuation plan included 5 emergency exits, including a 2nd floor fire escape and the back door through the office. The QMRP also acknowledged that the fire escape exit and the back door had not been used during drills within the past year. It should be noted that the four clients' bedrooms where all located on the second level.	W 441	Fire drills will be conducted using all available emergency exits including the 2nd Floor fire escape and the back door through the office.	6/15/09	
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview, and record verification, the facility failed to ensure effective infection control procedures were implemented, for three of four clients residing in the facility. (Clients #1, #2 and #3)	W 455			

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W 455	<p>Continued From page 13</p> <p>The findings include:</p> <p>1. On May 18, 2009, at 5:07 PM, Client #1 was observed with large amounts of saliva extending from his mouth down onto his shirt. The client wiped the saliva with his hands then wiped his hands onto the dining room table. Client #1's 1:1 staff did not encourage or direct the client to go to the bathroom to wash his hands. Interview with the 1:1 staff on the same day at approximately 5:15 PM revealed that he had received training on infection control.</p> <p>2. Observation on May 18, 2009, beginning at 5:33 PM, revealed Clients #1, #2, and #3 at the table being served dinner (cheese burgers, spinach, French fries, and milk is the beverage). None of the clients were observed to be asked to or independently washed their hands prior to consuming their dinner. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 5:40 PM confirmed that none of the clients had washed their hands prior to consuming their dinner.</p> <p>3. On May 18, 2009, at 4:14 PM, Client #2 flushed a toilet in the restroom located adjacent to his bedroom, then walked into the hallway without having washed his hands. When asked by this surveyor if he had washed his hands, he replied no and immediately entered another bathroom, on the 2nd floor. He ran his hands under water briefly, and then exited the bathroom stating the water was "still cold." He had not used soap and he wiped his hands on his pants as he walked down the stairs. [Note: Moments later, inspection of both bathrooms on the 2nd floor revealed there was no hand soap or paper towels available in</p>	W 455	<p>1. All staff will receive training on Infection Control and Universal Precautions. In the future, the QMRP/ Residential Manager will have quarterly trainings on Infection Control.</p>	6/22/09	

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W 455	Continued From page 14 either bathroom.] 4. On May 19, 2009, at approximately 3:48 PM, Client #2 was observed in the kitchen, holding the lid to the trash receptacle with his bare hands. A staff was with him at that time, offering him snacks. The client placed the lid back onto the receptacle, took a paper towel and held it steady while the staff poured snack mix onto the paper towel. Client #2 then began eating the food without first having received instruction or a reminder to first wash his hands.	W 455		
W9999	FINAL OBSERVATIONS The following observation was made during the survey process. It is recommended that this area be reviewed and a determination be made regarding appropriate action to prevent potential non-compliant practice: On May 19, 2009, at approximately 11:25 AM, review of Client #1's medical records revealed that the pharmacist had reviewed his medication regimen on August 22, 2008, November 4, 2008 and on February 10, 2009. The Qualified Mental Retardation Professional (QMRP) and RN were present at the time and they were asked if the pharmacist was scheduled to come in May. They replied that he had already been to the facility. Review of the visitor's log book confirmed that the	W9999		

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W9999	<p>Continued From page 15</p> <p>pharmacist had come on May 4, 2009. During this discussion, a review of Client #2's medical records revealed the same pharmacy review dates as those documented for Client #1.</p> <p>The RN retrieved Clients #3 and #4s' medical charts and presented documentation that the pharmacist had reviewed their medication regimens on May 4, 2009. Further interview revealed that Client #1's chart had accompanied him on a medical appointment that day and was, therefore, unavailable for the pharmacist's review. The QMRP and RN could not explain why Client #2's medications had not been reviewed on May 4, 2009. The RN replied "no" when asked whether the pharmacist had been asked to return to the facility that month to review the two clients' medication regimens.</p>	W9999	<p>In the future, the pharmacist will request all medical records. In the event any of the medical records are not available for review, arrangements will be made for the pharmacist to review the records at a later date.</p>	6/30/09

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1000 INITIAL COMMENTS

A licensure survey was conducted from May 18, 2009 through May 19, 2009. A random sample of two residents was selected from a resident population of one female and three males with various disabilities.

The findings of the survey were based on observations, interviews with residents, interviews with staff in the home and at two day programs, as well as a review of resident and administrative records, including incident and investigation reports.

1000

1082 3503.10 BEDROOMS AND BATHROOMS

Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.

This Statute is not met as evidenced by:
Based on observation and interview, the GHMRP failed to ensure the interior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner.

The findings include:

1. On May 18, 2009, at 4:19 PM, there was no hand soap or paper towels available for use in the 2 bathrooms located on the 2nd floor.
2. On May 19, 2009, beginning at 9:25 AM, a walk through of the facility that was conducted with the Qualified Mental Retardation Professional revealed there were no paper cup dispensers and no cups available for use in the 2

1082

1. Hand soap, paper towels, and cup dispensers will be available in all bathrooms. Management staff will check daily to ensure adequate supplies.

6/22/09

Health Regulation Administration <i>Constantine C. Reese</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	PROGRAM DIRECTOR <i>Prayan Director</i> TITLE	(X6) DATE 6/9/09
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I 082	Continued From page 1 bathrooms located on the 2nd floor.	I 082		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner. The findings include: On May 19, 2009, beginning at 9:25 AM, a walk through of the facility that was conducted with the Qualified Mental Retardation Professional revealed the following: 1. The dining room carpet had several large stains and was torn in four areas, presenting a potential trip hazard. 2. The seats on two of the chairs at the dining room table were detached. The seats moved readily when the person sitting on them shifted position, presenting a potential safety hazard. 3. There were dead bugs in the ceiling light fixture in the kitchen. 4. The bannister railing on the stairs leading from the front foyer to the 2nd floor was loose.	I 090	1. The dining room carpet will be replaced immediately. 2. The two chairs at the dining room table will be repaired. 3. The ceiling light fixture in the kitchen will be cleaned out. 4. The bannister railing on the stairs leading from the front foyer to the 2nd floor will be repaired.	6/8/09 6/8/09 6/8/09 6/30/09

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I 132	Continued From page 2	I 132		
I 132	3505.4(c) FIRE SAFETY 3505.4 Each GHMRP shall have on the premises the following items: (c) Records of fire inspection reports; This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the proper record keeping and documentation of all fire inspection reports. The finding includes: On May 19, 2009, beginning at 9:25 AM, a walk through of the facility that was conducted with the Qualified Mental Retardation Professional (QMRP), revealed that three out of five fire extinguishers did not have tags indicating a fire inspection had been conducted. The remaining two fire extinguishers had tags indicating expiration dates of January 2008. At approximately 10:15 AM, the QMRP and the House Manager were unable to locate records of any past fire inspection reports. There was no evidence that the GHMRP routinely had its fire extinguishers and other fire safety equipment inspected.	I 132	In the future, proper record-keeping and documentation of all fire inspection reports will be kept in the facility. All fire extinguishers will have tags indicating a fire inspection had been conducted and they will be in working condition.	6/30/09
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on the interview and review of the fire drill	I 135	Cross reference W441	6/15/09

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I 135	Continued From page 3 records, the GHMRP failed to conduct fire drills under varied conditions, for four of four residents residing in the facility. (Residents #1, #2, #3 and #4) The finding includes: Review of the GHMRP's fire drill records on May 18, 2009, at 10:00 AM, revealed staff documented having evacuated clients via the front, side, and basement door exits on all drills. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 10:20 AM, revealed that the facility's emergency fire evacuation plan included 5 emergency exits, including a 2nd floor fire escape and the back door through the office. The QMRP also acknowledged that the fire escape exit and the back door had not been used during drills within the past year. It should be noted that the four residents' bedrooms were all located on the second level.	I 135		
I 204	3509.4 PERSONNEL POLICIES Each employee shall be given a copy of his or her job description to review and sign at the beginning of employment. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have on file for review, current job descriptions for all new employees for two (2) of thirteen (13) files reviewed. (QMRP and S7) The finding includes: 1. On March 17, 2009, the Qualified Mental Retardation Professional (QMRP), stated that she	I 204	The Program Director will have the QMRP review and sign job description annually.	6/8/09

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I 204	Continued From page 4 began working in that position in October 2008. Review of the personnel files on May 19, 2009, beginning at 10:37 AM, revealed no evidence that she had been given a QMRP job description to review and sign at the time that she was promoted. At 12:28 PM, the QMRP confirmed that she had not been given a copy of her job description. She referred this surveyor to the corporate office. 2. On May 19, 2009, beginning at 10:37 AM, review of the GHMRP's personnel files revealed the GHMRP failed to provide evidence that one of the twelve direct care assistants (S7) had been given a copy of her job description for review and signature at the beginning of her employment.	I 204		
I 205	3509.5 PERSONNEL POLICIES Each job description shall be updated, rewritten, and reviewed with the employee when, the duties and responsibilities of the job change. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of updated and reviewed job descriptions, for 4 of the 8 direct care assistants whose assignments were changed to include provision of one-on-one support. (S1, S2, S3 and S12) The findings include: On May 18, 2009, at approximately 9:45 AM, interview with the Qualified Mental Retardation Professional (QMRP) and House Manager revealed that two of the four residents received one-on-one staffing support 24 hours a day, 7 days a week. On May 19, 2009, beginning at 10:37 AM, review of the GHMRP's staff schedule	I 205	The QMRP will have each employee review and sign one to one job descriptions annually.	6/22/09

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I 205	Continued From page 5 revealed that there were 8 direct care staff providing one-on-one support. Simultaneous review of personnel files revealed the GHMRP failed to provide evidence that 4 (S1, S2, S3 and S12) of the 8 staff (50%) had the contents of their job descriptions updated to reflect the role and responsibilities of a one-on-one.	I 205		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on staff interviews and record verification, the GHMRP failed to ensure MANDT (crisis intervention) training for one staff working with Resident #1, in accordance with his behavior support plan, for 1 of the 4 staff providing him one-on-one supports. (S12) The finding includes: On May 18, 2009, at 9:21 AM, an employee (S12) entered the facility. The Qualified Mental Retardation Professional (QMRP) and House Manager (HM) introduced him. The employee would provide Resident #1 with one-on-one support during the remainder of the 8:00 AM - 4:00 PM shift. He indicated that he had worked as the resident's one-on-one during the 4:00 PM - 12:00 AM shift for approximately a week and a half. The QMRP and HM confirmed his statement and described the training that S12	I 229	Cross reference W189	7/19/09

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I 229	Continued From page 6 had received during the past 2 weeks. A short while later, at approximately 9:45 AM, the QMRP and HM indicated that Resident #1's received one-on-one staff support 24 hours a day, 7 days a week. Further interview revealed that the resident's behavior support plan (BSP) incorporated the use of physical restraint as a last resort and staff were trained on MANDT crisis intervention techniques. On May 18, 2009, approximately 11:30 AM, review of Resident #1's BSP, dated April 30, 2009, confirmed that all staff working with him must be "trained and certified in nonviolent crisis intervention procedures... such as MANDT," to ensure the resident's safety. On May 19, 2009, beginning at 10:37 AM, review of the GHMRP's personnel files revealed no evidence that one of Resident #1's one-on-one staff (S12) had received MANDT training. At the conclusion of the survey, at approximately 5:10 PM, the QMRP acknowledged that S12 had not yet received MANDT training.	I 229		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure lab testing at the prescribed frequency, for one of the two residents in the sample. (Resident #2)	I 401	Cross reference W338	6/8/09

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I 401	Continued From page 7 The finding includes: On May , 2008, beginning at 3:33 PM, review of Resident #2's medical records revealed that he his diagnoses included depression, urinary incontinence and hypercholesterolemia, for which he was prescribed medications (Lexapro, Oxybutynin chloride and Simvastatin, respectively). In addition, he was prescribed a 1500 calorie low fat, low cholesterol, high fiber diet. Resident #2's physician's orders (POs) for May 2009 included instructions to "monitor liver function tests and lipid panel every 3 months." Review of past POs revealed that those labs had been ordered every 6 months. The lab order, however, had been changed to every 3 months, effective December 1, 2008. At 3:52 PM, review of his lab reports revealed that his LFT and lipid panel had been tested on December 18, 2008 and April 21, 2009 (4 months apart).	I 401		

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R 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from May 18, 2009 through May 19, 2009. A random sample of two residents was selected from a resident population of one female and three males with various disabilities.</p> <p>The findings of the survey were based on observations, interviews with residents, interviews with staff in the home and at two day programs, as well as a review of residents and administrative records, including incident and investigation reports.</p>	R 000		
R 122	<p>4701.2 BACKGROUND CHECK REQUIREMENT</p> <p>Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person.</p> <p>This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks had been obtained before employing or using the contract services of an unlicensed person, for 1 out of 12 direct support staff employed. (S11)</p> <p>The findings include:</p> <p>On May 18, 2009, at 10:25 AM, the Qualified Mental Retardation Professional (QMRP) agreed to provide documentation needed to show evidence of criminal background checks for all staff employed in the facility. On March 19, 2009, beginning at 10:37 AM, review of one direct support staff person's personnel record (S11)</p>	R 122	<p>All criminal background checks will be obtained and placed in their personnel records.</p>	<p>6/30/09</p>

Health Regulation Administration
Caroline A. Reese Propan Rivera
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE
6/9/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2009
NAME OF PROVIDER OR SUPPLIER CMS		STREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 122	Continued From page 1 revealed no documentation available to verify that a background check had been obtained prior to employment. Note: The file contained a job description which the staff person had signed on June 5, 2008. It should be noted that there were 8 other direct support staff (S1, S2, S3, S4, S5, S6, S7, S9 and S10) for which there was no evidence of comprehensive criminal background checks, to include all jurisdictions in which he/she lived or worked (see R125).	R 122		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check, for 10 of the 14 non-licensed employees. The findings include: On May 18, 2009, at 10:25 AM, the Qualified Mental Retardation Professional agreed to provide documentation needed to show evidence of criminal background checks for all staff employed in the facility. On March 19, 2009, beginning at 10:37 AM, review of the materials presented revealed the following:	R 125	Cross reference R122	6/30/09

Health Regulation Administration

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R 125	Continued From page 2 1. A March 18, 2009 background check for the District of Columbia had been documented for the House Manager (HM). However, her personnel records indicated that she had lived in Delaware from August 2003 - May 2008. In addition, she was living in Prince Georges County, MD at the time that she applied for employment in November 2008. There was no evidence that background checks had been obtained in those jurisdictions. It should be noted that she began employment with this facility on November 26, 2008, more than 3 months before the DC background check was obtained. 2. A District of Columbia background check had been documented for S1. However, his personnel records indicated that he had worked in Alexandria, Virginia from 1990 until he applied for employment on September 22, 2008. There was no evidence that a background check had been obtained in that jurisdiction. 3. A District of Columbia background check had been documented for S2. However, his personnel records indicated that he had worked in Maryland from March 2003 until September 2005. There was no evidence that a background check had been obtained in that jurisdiction. 4. A background check for the District of Columbia had been documented for S4. However, his personnel records indicated that he lived in Prince Georges County, MD at the time that he applied for employment in 2008. In addition, his records indicated that he had worked in Maryland from September 2002 until January 2003. There was no evidence that a background check had been obtained in Maryland.	R 125		

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R 125	<p>Continued From page 3</p> <p>5. A background check for the District of Columbia had been documented for S5. However, his personnel records indicated that he lived in Prince Georges County, MD at the time that he applied for employment in 2008. There was no evidence that a background check had been obtained in that jurisdiction.</p> <p>6. A District of Columbia background check had been documented for S6. However, her personnel records indicated that she had worked in Maryland from November 2007 until she applied for employment on June 5, 2008. There was no evidence that a background check had been obtained in Maryland.</p> <p>7. A background check for the District of Columbia had been documented for S7. However, her personnel records indicated that she was living in Prince Georges County, MD at the time that she applied for employment in March 2009. In addition, her personnel records indicated that she had been employed in Maryland for 7 months in 2006. There was no evidence that background checks had been obtained in Maryland.</p> <p>8. An April 11, 2003 background check for the District of Columbia had been documented for S9. However, her personnel records indicated that she lived in Prince Georges County, MD. There was no evidence that a background check had been obtained in that jurisdiction.</p> <p>9. A background check for the District of Columbia had been documented for S10. However, his personnel records indicated that he lived in Prince Georges County, MD at the time that he applied for employment. There was no evidence that a background check had been</p>	R 125		

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R 125	<p>Continued From page 4 obtained in that jurisdiction.</p> <p>It should be noted that there was no work history provided for S3. Although a background check for the District of Columbia had been documented, the absence of work history information prevented verification that all applicable jurisdictions had been checked.</p> <p>It should be further noted that to there was no background check evidenced for S11. (See I122)</p>	R 125		
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